UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF LOUISIANA
SHREVEPORT DIVISION

AKEEM HENDERSON, et al.,

Plaintiffs,

vs.

CASE NUMBER

5:19-CV-00163

WILLIS-KNIGHTON MEDICAL CENTER d/b/a Willis-Knighton South Hospital,

Defendant.

DEPOSITION OF

RICHARD M. SOBEL, M.D.

November 26, 2019

10:02 a.m.

105 Tivoli Gardens Road

Peachtree City, Georgia 30269

Thomas R. Brezina, CRR, RMR, CCR-B-2035

EXHIBIT
tabbies
12

A Not any longer. I would have in the past.

Q Looking at the bottom of your report on page 4 where you reference stabilization, and that is strictly from the interpretive guidelines; correct?

A I think so. I might have cleared up some of the verbiage if it wasn't entirely clear.

Q Well --

A I don't see a -- no quotes, per se, but I'm sure it mirrors it if it's not an exact verbiage.

Q What is your understanding of the term, quote, within reasonable medical probability?

A Well, more likely than not. So if it's more likely than not that a patient would have an unstabilized emergency medical condition, you simply could not discharge them.

Q So reasonable medical probability is what?

A Reasonable medical probability usually refers to a 51 percent chance in terms of medical standards, but in EMTALA I think it's actually a bit different. So if you have an unstabilized emergency medical condition that you acknowledge and are aware

of, you have actual knowledge of, then the EMTALA standard would be to continue stabilization and not discharge a patient. But the verification process I think is what is referred to here.

So this would be the verification process by a physician, by a hospital, by the staff, by consultants that an emergency medical condition is adequately stabilized. That did not occur in this case.

Q No. You said by the staff and consultants? What about the emergency room physician?

A Yeah.

Q Before we go there, are there any changes or revisions that you feel need to be made to your report?

A Well, I think the numbering needs to be cleared up.

Q By the numbering you just mean the paragraph numbering where it was two fives?

A Yes. I think there may be two sixes as well. I don't know what happened from page 8 to page 9. It looks like everything went out of sync there. So, eight. Looks like the next one should be six, seven, eight, nine, ten, 11 I guess it would

she was frequently treated with Rocephin, a third-generation cephalosporin. Sometimes she was released; sometimes she was admitted.

Q And the cephalosporin and Rocephin would be an antibiotic for an infection?

A Yes.

Q Corticosteroid is what? What does that do?

A It's a steroidal anti-inflammatory medicine, so it helps clear the air -- the small airways in the lungs of debris and inflammation.

Q And you saw where this particular child had been admitted for problems with her respiratory disease twice within the six months prior to this February 10th, 2018, visit?

A Apparently. That is what I have written, yes.

Q In the next paragraph you mentioned Dr. Tran, T-R-A-N, who is a pediatric hospitalist. Why did you reference that in this report?

A Well, this is an example of the child being admitted under similar circumstances, but I think in a less dire condition than she had when she presented on February 18th -- February 10th of 2018.

So her pulse oximetry was 91 percent,

and as per Dr. Tran's discharge summary the patient was, quote, tachypneic with respirations in the 30s and oxygen saturation of 91 percent. She improved clinically and remained on room air, and here -- I think it should be "her" -- respiratory distress involved (sic).

So in this particular case in February her condition was similar but worse, so her respirations were even higher. Her pulse oximetry was the same. She was in obvious respiratory distress. She was discharged. This is where you have actual knowledge of an emergency medical condition that within reasonable medical probability was not stabilized and the discharge of the patient.

Q So in this July of 2017 admission referenced in that paragraph, was that the only problem that the child had at that time?

A I don't know about that.

Q So she could have -- she was hospitalized with other co-morbidities besides just the --

A Well, I would not be surprised if she had a respiratory infection. She actually had a pneumonia when she arrived on February 10th. I can't say I specifically recall. I put it in

Q And how do you define respiratory distress in this situation?

A Well, I think I defined it pretty well. This is a classic description of it. In the next paragraph on page 6, "Ailiyah presented in a, quote, tripod, unquote, position with frank respiratory distress. Per Susan Rainer, RN, at 2:05 a.m. she was, quote, distressed; quote, uncomfortable; and, quote, anxious."

And then I went on to explain what -- the clinical implications of the tripod position. It's the physical stance which may be the hallmark of children experiencing respiratory distress. It would be very typical, so this would be an obvious case of respiratory distress.

Q And the tripod position was noted by the nurse, is that correct, in her 2:05 note?

A I believe it was at 2:05.

Q And we might go ahead and attach a copy of the record.

MR. ROBISON: Sedric, are you there?

MR. SEDRIC BANKS: Yes, please.

MR. PUGH: These are the ones that I e-mailed to you.

BY MR. ROBISON:

Q Yes. It's pages -- it says at the top right-hand corner, "Page 761 of 1,758," and that would be Defendant's Exhibit 7, I believe.

A I don't have the Bates stamp, but --

Q I'm going to hand you a copy so that you can -- thank you.

(Exhibit Number 7 was marked for identification.)

MR. SEDRIC BANKS: While we're doing housekeeping, is there an objection to attaching the protocol that we were mentioning earlier on -- the respiratory protocol that was furnished in another case?

MR. ROBISON: Yes. I think we attached it as Exhibit 6, that chart.

MR. SEDRIC BANKS: That is the Willis-Knighton? I'm going to talk about the Willis-Knighton document that was produced in another case that you-all talked about also. Is that protocol attached, or is it just the --

MR. PUGH: The flow chart.

MR. ROBISON: Yes. The flow chart is attached as Exhibit 6. We're not agreeing that it's applicable, but we attached it.

should be hooked up to the monitor with continuous pulse oximetry. Should have continuous plethysmography, respiratory rate, the heart rate. Should be on supplemental O2.

This is a child that's got to be wired for sound, and IV is -- needs to be started. Intravenous steroids, magnesium, continuous bronchodilator therapy. The die is cast when this child arrives at the hospital. This is a child that needs to be admitted.

Q Under -- since we're looking at that, on the nurse's notes we're looking at vital statistics at 0323, what do those say? The pulse ox goes to 99 percent, correct, and 99 percent is good?

A No. This is the result, more likely than not, within reasonable medical certainty, if you would like to use the term, of the patient getting a neb treatment --

Q So she --

A -- with oxygen.

Q So the patient was treated and got better?

A So -- no. So this is the pulse oximetry that is measured on high-flow O2.

Q Where is that documented?

A So it's not a room air pulse oximetry.

Q And where is that part documented, that she is on oxygen at that point?

A Well, look at time of the nebulizer treatment. So there is an albuterol nebulizer treatment that is begun at 3:16. That is given with high-flow O2.

Q Is that appropriate? Is that an appropriate treatment?

A Yes. Yes, it's appropriate. So if you note in the previous records, they document pulse oximetry on room air, especially when she went home. There was a pulse oximetry documented on room air. That's what you need. In this particular case the first pulse oximetry was on room air, so that is prior to the neb. The neb is given with oxygen, and the second pulse oximetry, there is no documentation of being on room air. That it's taken simultaneous with an albuterol treatment, which is given with oxygen, so --

Q Before we get there, since we're looking at administered medication, which would be in the nurse's notes continued -- I think you're looking at that now?

A On 767.

In other words, there is no auscultation of the lungs. There is no comment as to whether or not the child is using accessory muscles or whether there are retractions. So there is no comment by the staff, nursing staff, or the respiratory therapist. That note was by the RN.

Q If you look on --

A There is no comment that she actually listened to the lungs.

Q If you look up above that, at 0211, it says, "Child being held by parent" under ED course.

A Yes. That is definitely different than fully mobile and ambulatory.

Q And you'd -- no problem with the four-year-old being held by the parent; right?

MR. SEDRIC BANKS: Counsel, let me interrupt you just for a second because it looks like we're on multiple tracks here. Is there an explanation of why we're dealing with two different sets of medical records?

MR. PUGH: I don't know what you gave him. I pulled the chart from the hospital, and that's what this is. We didn't provide you with --

MR. SEDRIC BANKS: Well, we got it from

the hospital, and I see the -- just for distinguishing purposes, our medical records were printed March the 6th, 2018, and the records that you are showing Dr. Sobel were printed February the 11th, 2018, and I'm wondering, well, what possible explanation is it? We're dealing with two different sets of medical records.

MR. ROBISON: And he's actually looking at the set that you gave him and the set that we have, and they actually look pretty similar.

MR. SEDRIC BANKS: Yeah, I understand.

MR. ROBISON: We'll have to figure that out. There were a few changes. Not changes, but -- I don't know the answer.

MR. SEDRIC BANKS: Well, I think there is something we need to deal with, and I certainly feel for the doctor trying to answer questions from two different sets of medical records, one he's seen before and expressed an opinion on, and now he's presented with a different set of medical records, which purports to be the same, and we all know they are not the same.

BY MR. ROBISON:

Q Dr. Sobel, for the record, are the two pages that you are looking at, practically identical?

A Well, so far I've seen a few differences, one being the correction at the end, and then it looks like most of the differences that I have seen otherwise are minor and not -- nonsignificant, but the correction at the end is fairly significant.

Q Now, what are you referencing, the correction at the end? The crossout?

A Yes. 268.

Q We will get to that in a minute, then. I want to go back to that administered medication section on page 767.

MR. PUGH: Yes.

BY MR. ROBISON:

Q Did you see where the patient was given the DuoNeb at 2:04; correct?

A Yes.

Q And then at 2:13 is noted as being seen by the attending physician?

A Yes.

Q And there is an influenza culture, so

at 2:11 for the last time, and then there is a treatment, and then this note has 2:33. So the treatment worked; right? Unless you're just negating --

A No. Well, you know, the correction is very interesting because it lists tripodding at 2:22. The time of physician exam is 2:13. These are the computer clock times when you actually physically document, so this is not a time of the exam necessarily. I think these are computer top -- clock times when the doctor did the documentation, so there appear to be a number of discrepancies that are really difficult to understand.

Q So perhaps the correction is from 2:11 to 0222; is that right? They retimed it.

(Discussion ensued off the record between Mr. Pugh and Mr. Robison.)

THE WITNESS: I don't know.

BY MR. ROBISON:

Q Well, we do have, however, is that according to the physician, at 2:30 -- 0233 the patient was negative for dyspnea on exertion, so is it --

A No.

Q -- possible that she got better after

That is not accurate.

Q So at that point in the doctor's opinion the patient is now stabilized, according to what we just read?

A Well, he doesn't use the term "stabilized." He states, "Return to baseline."

Q And what is baseline?

A Well, as you said, with BPD the baseline could be not that great. Baseline goes from being home O2 dependent and having nebs every few hours to just mild disease which is associated with asthma.

Q And baseline --

A It does not -- what is missing is a physical exam. That is why there is no possibility they could have determined that this patient would not materially deteriorate. There is no physical exam. Not by the doctor, not by the nurse, not by a respiratory therapist. There is just some conclusions here: Improved; return to baseline. You've got to listen to the lungs. You've got to examine the child. You've got to recognize the abnormal vital signs which are persistent at 3:23.

Q Are you assuming that the doctor did not examine the child?

because you have a child that came in, in near respiratory failure, failing home meds.

And then you have not given steroids or magnesia, which is another arm of treatment for this, right from the beginning. You can't see if there is actually a response to steroids because it takes essentially hours for steroids to kick in for the most part, and you are just giving a shot going out the door. There is no way that you could predict that there would not be material deterioration of the patient's condition. More likely than not, there will be.

Q And what fact are you basing that on?

A The presentation of the child.

Q Even though it improved, you're still assuming that it's going to get worse?

A Oh, sure. This is status asthmaticus by definition. For you to -- for you to presume that it's completely resolved and that there is no risk of material deterioration in less than two hours is difficult to fathom and very disparate because you're just not going to send home children coming in, in respiratory distress, particularly one with this kind of history: Autism, previous admissions, home nebs, bronchopulmonary dysplasia.

that it takes 20 to 30 minutes of washout time for a valid reading of O2. What does that mean?

A Well, that means when you increase the FIO2 or the percentage of oxygen in the air by giving supplemental oxygen, the oxygen replaces the nitrogen in the lungs, so essentially you're going to a different planet. Planet Earth is 21 percent.

If you put a child on 50 percent, it's like you're breathing an oxygen concentration of 50 percent in the atmosphere, so that is going to artificially increase your oxygenation, and that is reflected in the pulse oximetry. That is why you have a pulse oximetry of 99 percent in this case: Because you've supplied supplemental oxygen. It has to wash out over time, so you start breathing the regular oxygen-level air. It's 21 percent. You got to breathe that for a while.

And the 50 percent oxygen atmosphere that you have delivered to the patient, the term is washout. It washes out, and the nitrogen comes back in and replaces the oxygen. After that happens and the supplemental oxygen is washed out, then you can repeat the pulse oximetry and see if it's stable, and that is what the policy or the protocol is reflecting: That you need some time for the washout

of oxygen, the supplemental oxygen to wash out.

Q Does it always -- are those times preset for a child that is four years old with compromised lungs from birth? The 20 to 30-minute time?

A Just gave a rule of thumb. You can tell how fast it's deteriorating. You could maybe make the call in just a few minutes if it starts precipitously dropping. So what you don't have is verification of a -- of a room air oxygen that is greater than 95 percent. So there is no way you can determine that this child is not going to materially deteriorate. Tachycardic, breathing too fast, and you don't have a properly obtained pulse oximetry, and you don't have anybody that is reporting a lung exam.

Q Does albuterol have the effect of increasing a patient's heart rate?

A It can.

Q It can, or it does? That is one of the listed --

A It can. It can. It can actually go down, so it depends. If you are effective in treating the bronchospasm and the child is out of the tripod position and not using any accessory

A That's a four-year-old, the patient. So the -- you can't really rely on a four-year-old to tell you their asthma attack is resolved. That's what I am saying. The condition has returned to baseline, again, we don't know what the baseline is, and Dr. Easterling didn't know what the baseline was. I don't see how he could.

This is a patient with some degree of chronic lung. He doesn't know what the pulmonary function tests show or -- I think he may have seen the patient once before, but as far as returning to the baseline, we don't know what the baseline is. The problem is, again, there is no exam.

So you can't determine within a reasonable medical probability that there won't be any material deterioration unless you do an exam, unless you wait for the steroids to work, unless we wait for the tachycardia to resolve; the tachypnea, the rapid respirations to resolve; the pulse oximetry to return to normal on room air.

This is a case of status asthmaticus. There was no way that the staff of Willis-Knighton, to include the nurses, if there is a respiratory therapist -- I don't know -- or the doctor can determine that this condition of status asthmaticus

2:05. That is really an indisputable emergency medical condition with potentially dire consequences. In this case the consequence was death. So everyone in the emergency department, according to these records, had actual knowledge that the child presented in a dire condition.

The nurses documented. The doctors -- confirms it in his note. The doctor says he reviewed the -- the nurse's documentation and confirmed it, so that is what I mean by actual knowledge. The doctor may have been at the bedside at 2:13 when the child was still tripodding.

It's entirely likely, so everybody should be aware that this kind of presentation can be associated with death, and the child can't be discharged in less than two hours.

Q For purposes of EMTALA is there a requirement for the length of time that a hospital must keep a patient?

A It depends on their condition. So EMTALA is essentially over for the most part after a child -- well, after a patient is admitted with few exceptions. Few exceptions. If the medical screening and stabilization is continuing, there may be unusual cases where EMTALA remains in force, but

by and large, after the patient is admitted or properly transferred, your obligations under EMTALA have concluded.

Q Under Number 7, even the administration of injectable steroids, discharge without reasonable period of observation, that is where you're saying that there should have been more than 15 minutes of observation after the Decadron?

A Should. Not only for an adverse reaction, but to see if it's working.

Q What in these records indicates to you that this unstabilized patient had an obvious risk of nearterm respiratory failure?

A Number 1 would be the initial presentation. We went over that. The physical exam, the hypoxia, the rapid respiratory rate, the rapid heart rate, the persistence of the rapid respiratory rate, rapid heart rate, the need for another neb. The need for steroids, which I think was pretty obvious right from the beginning.

So it's conspicuously obvious that this is a child that can reexacerbate during the night and requires inpatient observation. The mother is told direct from the beginning that the nebs at home didn't work and she came into the emergency